APPENDIX 3- KEY POINTS FOR ED CLINICIANS

ED Clinicians:

1. Older patients, particularly those with multiple co-morbid illnesses, have the highest mortality rate with COVID-19 with a case fatality in China for patients over 80 years of 21.9%.
2. Health care systems and community health providers should have rapidly accessible alternatives for COVID-19 testing other than the ED. Opportunities to expand and utilize telehealth care in the evaluation of patients will limit risk of exposure and spread to those most vulnerable, and decrease overcrowding.
3. Per current Centers for Disease Control (CDC) guidelines, symptomatic (*fever, cough*) older adults and those with chronic medical conditions or who are immunosuppressed should have a low threshold for testing for COVID-19. Test for influenza first.
4. During a shortage of testing kits and their reagents, criteria should be followed to ensure those who are at highest risk receive testing.
5. The Centers for Medicare and Medicaid Services (CMS) has instituted emergency measures to expedite evaluation and disposition of older adults. These included expanding availability of telehealth and waiving the three-day hospital rule prior to SNF placement.
6. Because risk of COVID-19 spread is high in the ED and resources may become limited, protocols should direct well patients to other alternatives, including drive-through testing and telehealth assessments. ED resources should be reserved for seriously and critically ill older adults who are frail, have multiple co-morbid illnesses, and/or significant functional impairments that may need greater medical attention that cannot be addressed at alternatives.
7. As much as possible, place older patients with non-respiratory symptoms in a separate part or zone of the ED, away from those with suspected respiratory infections. This will reduce risk of exposure to potential COVID-19.
8. With the use of masks in the ED and healthcare setting (both by patients and clincians), be sure to communicate slowly and clearly for those with sensory or cognitive limitations. Patients will no longer be able to read lips and clinicians and caregivers wearing masks may be disorienting for those with denentia and other cognitive impairment.
9. Ask patients and caregivers about their expectations and goals of care early in the evaluation. Now is the time to ask and document advanced directives patient and wishes in preparation for potential severe or critical illness.
10. Because testing is followed by recommendations for quarantine or isolation, the ED provider should work with their Area Agency on Aging (AAA) and/or Department of Public Health (DPH) to provide community resources for home delivered groceries and medications. When available, social worker assistance for these cases will be very helpful and hospitals should increase social worker availability in the ED where possible.
11. ED and hospital administration should establish protocols with referring residential and nursing homes and senior living centers for transfers, communication standards, and a specific plan whether residents with URI symptoms may be accepted back to their facilities with or without COVID-19 testing. Stable COVID-19 patients do not necessirily need hospitalization.
12. Protocols should be implemented for paramedics to transfer patients from the community or facility to the most appropriate location for treatment or testing depending on the patient's acuity and the need for testing.
13. Provide interpersonal support to older patients and caregivers who are at particular risk for anxiety and loneliness during quarentine. This includes referrals to online communities that encourage community connections.
14. During busy ED visits, continue to complete clinical history and examination of those who have the most complex needs, involving the multidisciplinary staff (Pharmacy, social work) as needed.
15. Check CDC, local Department of Public Health (DPH) and/or AAA websites *DAILY* for updates – the situation is rapidly changing.